SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

HOME AND COMMUNITY BASED WAIVER Policy Manual	Section: CASE MANAGEMENT SYSTEM
	Subject: Year End Money

DEFINITION

Year End Money is distributed to the case management teams toward the end of the fiscal year and is used to meet the needs of current members or provide one-time or temporary services to individuals waiting for services. When available, year-end money is subject to approval by the Community Services Bureau (CSB). Refer to HCBS 899-1 for Request for Year End Money form. CMTs should only submit year-end request forms when notified by the CMB that there is money available.

REQUIREMENTS

Year End Money is used for the following purposes only:

1. Environmental Modifications
2. One time purchase of Specialized Medical Equipment and Supplies
3. Temporary increase in existing Plan of Care (POC) e.g., if a family needed extra respite or supervision time and didn't have funds left in their current POC.
4. One-time or temporary services to individuals on the waiting list.

PROCEDURE

Individuals Enrolled Only to Access Year End Money—A POC short form (DPHHS-SLTC-135B) and cost sheet must be completed for individuals enrolled into the HCBS program to access Year End Money. Instructions for the form are in HCBS 899-11B. For members enrolled only under the year-end money criteria, the hourly case management rate must be used. This rate covers time spent with the member, family members, providers, and completing the paperwork. It does not cover travel time to and from the member's home. Case managers should keep a log tracking their time and total it upon submission of a claim.

Individuals Currently on HCBS Caseload—For members already enrolled in the program, amend the current POC and cost sheet. Use the empty lines on page 2 of the cost sheet for services provided with year-end money. The hourly case management rate does not apply to this group of individuals.

Over Cost Plans of Care—The Department and the Regional Program Officer (RPO) will already have approved the year-end expenditures. Therefore, prior-authorizations for over cost plans of care resulting from year-end expenditures will not be required.

BILLING

All Centers for Medicare and Medicaid Services (CMS) 1500s or 837-P claims must have a date-of-service within the fiscal year during which the year-end money was distributed. This should be the date a service was provided, the date an item was ordered, or the date an agreement was signed by the provider to provide services such as environmental modifications.

NOTE OF CAUTION

Individuals enrolled must still meet all eligibility criteria (Level of Care and financial eligibility for Medicaid). Do not put individuals on the program just for a Medicaid card. Do not put anyone on the program for temporary services that you will not be able to discharge before the end of the fiscal year or incorporate into your current caseload by the end of the fiscal year. All required forms, except the Psychosocial Summary (DPHHS-SLTC-143) and Plan of Care (DPHHS-SLTC-135), long version must be completed.